THE KANSAS AREA AGENCIES ON AGING ASSOCIATION

Meeting the Needs of Older Kansans

CIRCLE of CAREGIVING

Medicaid Cost Containment Alternatives & Potential Pilot Programs
February 20, 2011

The Kansas Area Agencies on Aging Association (K4A) represents the 11 Area Agencies on Aging (AAA) in Kansas, who collectively serve all 105 counties of Kansas. In Kansas, Area Agencies on Aging plan and coordinate the delivery of publicly funded community-based services that seniors and their caregivers need. The Area Agency on Aging system is funded by federal, state and local resources, and administered locally. Service delivery decisions are made at the community level—often in the homes of the seniors who need those services. The Area Agencies on Aging carry out their federal mandate as "the Leader" on aging issues at the local level. The Kansas Area Agencies on Aging Association works to improve services and supports for all older Kansans and their caregivers.

We appreciate the opportunity to present cost containment recommendations for Medicaid. The focus of the Area Agencies on Aging is to meet the needs of our senior population while being as cost-effective and fiscally responsible as possible.

The following recommendations from the Kansas Area Agencies on Aging Association are concepts/initiatives to consider:

- **HCBS-Frail Elderly Waiver Program Service Flexibility.** This would change the services offered so that the client may not have all of their needs met but basic needs are met to keep them living in their home. There would be some shared risk in the program. Currently Medicaid requires that all health and safety requirements must be addressed. This process is one that is currently utilized in the Senior Care Act program where the client's minimum needs are met. The average cost per Senior Care Act client is around $100 monthly, and the average cost per HCBS client is $1,060 monthly. This could significantly reduce the cost of the HCBS-FE waiver. If half the plans of care were reduced by 20%, this would produce a savings of roughly $8 million per year.

- **Care Management/Care Coordination Stationed at Hospitals (Hospital Discharge and Transition Services Project).** Accept and fund proposals from Area Agencies on Aging for pilot projects that provide care coordination and care management at the time when Medicaid-eligible seniors (60+ population) are admitted to hospitals. These tested models allow AAA case managers to connect and interact with seniors and caregivers at the bedsides and plan for cost-saving in-home services supported by family caregivers before hospital discharge. Use the Coleman transition model of hospital transition.

  For seniors who are already on Medicaid Home and Community Based Service Frail Elder Waivers, provide an "enhanced service package" that includes pre-discharge contact and post-discharge follow-up and monitoring for 60 days. AAA Case Managers shall help seniors and their caregivers learn about the chronic health conditions affecting their health, their medications and symptom management. Case managers will also provide support and intervention as appropriate concerning primary care issues related to the discharge plan.

These models will improve transitions from hospitals to home settings by identifying and addressing customers' post-hospitalization needs. The success of post-hospital discharge plans will be significantly enhanced and re-admissions to hospitals and utilization of nursing homes for these Kansans will be reduced.

The project would be piloted in three communities that represent the wide range of population demographics in Kansas. We suggest it be carried out with the Medicaid population age 60 and above. We anticipate that our proposed interventions will divert 40% of hospital discharges from nursing home placement to community-based care in our target communities. The Medicaid savings generated by this project will be dependent upon the communities used in the pilot project.

- **Single Point of Entry Model for Assessment and Plan of Care Development.** Move the initial client functional assessment and plan of care (POC) development components for individuals on the Home and Community Based Services – Frail Elderly Waiver (HCBS-FE) back to the Area Agencies on Aging (AAA's) who serve as the single point of entry for the Older Americans Act services, the Senior Care Act program and the majority of seniors on the HCBS-FE waiver program. This would ensure that there is consistency in assessment and POC development that meets identified needs of the seniors, maximizes informal and community resources and is not influenced by home health service providers, payroll agencies or caregivers who can benefit from higher plans of care. This model allows for the coordination of other available community services for seniors and caregivers. Choice of Targeted Case management providers and in-home services agencies can be offered after the initial casework is completed.

- **Centralized Aging/Disability Eligibility Assessment (Rep. Bob Bethell Plan)**
  Under this plan, the Area Agencies on Aging become Aging and Disability Resource Centers. These centers in the state would be the single point of entry/assessment/plans of care for both aging and disability services. This creates a system that would be centralized and since the Area Agencies on Aging are not providers of services or payroll agents, it eliminates the conflict of interest/increased costs. The benefit would be centralized system, elimination of multiple administrations/systems across senior/disability services. It eliminates the fracturing of the service system and creates a one-stop shop for aging/disability services.

- **CARE Assessment.** Improved outcomes, saving and diversion from nursing facilities are possible with changes to the CARE assessment 30-day follow-up process. Currently a case manager is required to make a phone at 30-day mark to find out where the individual is residing. If a 30-day in-person follow-up were required, it would allow a case manager to present community service option to the individual.

  Experience has shown the longer a person is residing in a nursing home the less likely the individual is to move back to the community.

- **Self-Directed Care Changes.** Under self-directed care within the waiver, payment to family members would be an option of last resort or number of hours a family member could provide is capped. Regularly area agencies on aging and their association are contacted by family members who have heard through the grapevine that they can be paid for the care that they have been providing for their loved one.

- **Pre-Admission Screening for Assisted Living Facilities and Homes Plus.** Assisted living facilities and Homes-Plus have become the nursing home facilities of recent times without the regulation and oversight.

By requiring a standardized assessment (similar to CARE assessment requirement) prior to admission, it provides an opportunity to educate the individual/family about lower cost community options.

The CARE program's purpose is to provide a pre-admission screening and resident review (PASRR) on individuals seeking or receiving nursing home care to ensure that individuals with mental illness, intellectual disability and/or developmental disability do not move into or continue to stay in a nursing home if they can be better served in a less restrictive environment

- **Cost Cap Issue** - In the Ohio PASSPORT program, an individual's initial plan of care cannot exceed 60% of the cost of nursing home care.

- **AAA Managed Care Model** - The Area Agencies on Aging (AAA) in Kansas have been the privatized homegrown system with over 35 years of experience working with Kansas seniors. We are experts in controlling costs while maximizing family involvement in care for the senior population. The Area Agencies on Aging have shown the capacity to change with the times and adjust to the needs of the senior while efficiently managing the resources of the taxpayer.

  We suggest the project would be piloted in three communities that represent the wide range of population demographics in Kansas. We suggest it be carried out with the Medicaid population age 60 and above.

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